QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Kerry-Ann Long**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	1180/2009
DELIVERED ON:	20 September 2011
DELIVERED AT:	Brisbane
HEARING DATE(s):	16 August 2010
FINDINGS OF:	Christine Clements, Deputy State Coroner
CATCHWORDS:	Coroners: inquest, death in custody, natural causes; adequacy of medical and emergency treatment

REPRESENTATION:

Counsel Assisting:	Ms A Kirkegaard
Dept Community Safety, Qld Corrective Services	Ms M Zerner
Sisters Inside	Ms D Kilroy

The *Coroners Act 2003* provides in s45 that when an inquest is held into a death in custody, the coroner's written findings must be given to the family of the person who died, each of the persons or organisations granted leave to appear at the inquest and to various officials with responsibility for the justice system. These are my findings in relation to the death of Kerry-Ann Long. They will be distributed in accordance with the requirements of the Act and posted on the web site of the Office of State Coroner.

Introduction

Ms Long was a 42 year old woman who died in the Princess Alexandra Hospital Intensive Care Unit on 4 February 2009. At the time of her death, Ms Long was serving a short custodial sentence at the Brisbane Women's Correctional Centre (BWCC).

Ms Long had a long history of intravenous drug use and at the time of her death, was on the methadone program. Her health was generally poor. She had previously been diagnosed with hepatitis B and hepatitis C and was being treated for depression. She was also taking medication for rheumatoid arthritis.

At approximately 5:15pm on 3 February 2009, Ms Long was observed to be distressed after a phone call with her father. She collapsed in the exercise yard shortly afterwards and lost consciousness. BWCC staff immediately called a Code Blue and instituted continuous resuscitation efforts until the paramedics arrived at 5:45pm. On assessment by the paramedics, Ms Long was noted to have a low Glasgow Coma Score and her left pupil was dilated.

Ms Long was then transported by ambulance to the Princess Alexandra Hospital (PAH) emergency department. Her pupils were fixed and dilated on arrival. A CT scan revealed extensive subarachnoid haemorrhage with cerebral oedema. A CT angiogram noted an 8.8mm x 8.9mm anterior communicating aneurysm.

Neurosurgical review determined that Ms Long had suffered irreversible brain damage and was likely to die within 24 hours. She was admitted to the intensive care unit for further management until her family could be contacted. After a discussion with her family the following morning, life support was withdrawn at 2:55pm and Ms Long died in the presence of family members at 4:10pm that afternoon.

Because Ms Long was in custody, her death was reported to the State Coroner for investigation and inquest.[1]

These findings:

[1] s8(3) defines "*reportable death*" to include deaths in custody and s7(2) requires that such deaths be reported to the state coroner or deputy state coroner. S27 requires an inquest be held in relation to all deaths in custody

- confirm the identity of the deceased, the time, place, circumstances and medical cause of her death;

- consider whether the actions or inactions of any person contributed to the death;

- consider whether the medical and emergency treatment afforded to Ms Long while in custody was adequate and reasonable; and

- consider whether any changes to procedures or policies could reduce the likelihood of deaths occurring in similar circumstances or otherwise contribute to public health and safety or the administration of justice.

The investigation

Detective Sergeant S R Wild, then of the QPS Corrective Services Investigation Unit (CSIU), conducted the investigation.

Detective Sergeant Wild was informed of Ms Long's impending death when her life support was withdrawn at 2:55pm on 4 February 2009. He attended the PAH intensive care unit a short time later.

Ms Long died at 4:10pm in the presence of family members. Ms Long's body was identified by her sister to registered nurse Darren McGeough at that time. Mr McGeough subsequently identified the body to Detective Sergeant Wild. Ms Long's death was formally reported to CSIU at approximately 5:00pm.

Several other patients were in the intensive care unit at the time of Ms Long's death. She had been under continuous escort by corrective services officers since her transfer to hospital the preceding day. A statement obtained from Corrective Services Officer Sarah Tomkins indicated she and fellow officer Justine Donaldson maintained visual surveillance of Ms Long at all times since relieving the previous shift on the morning of 4 February 2009, other than when medical staff removed Ms Long's life support.

Given these circumstances and Detective Sergeant Wild's assessment that there were no suspicious circumstances surrounding Ms Long's death, arrangements were made to remove her body from the intensive care ward. Police then accompanied Ms Long's body to the Queensland Health Forensic and Scientific Services mortuary for autopsy.

Dr Ong performed an external and full internal autopsy on the morning of 5 February 2009. The autopsy was observed by officers from CSIU and the QPS Coronial Support Unit.

Further inquiries made by CSIU about the circumstances of Ms Long's death included obtaining the correctional centre and hospital medical records, as well as the medical records maintained by Ms Long's general practitioner, Dr

Baster. The investigating officer seized a recording of the phone call Ms Long made shortly before her collapse, as well as footage from the CCTV camera that monitored the area of the exercise yard where she collapsed.

Most of the 27 other prisoners who were accommodated in the same unit as Ms Long were interviewed on 4 February 2009. Of the remainder, only two prisoners were unable to be located and re-interviewed at a later date. All these interviews were recorded.

The investigating officer also obtained statements from Ms Long's father, her former de facto spouse, Ms Long's close friend, the arresting officer, the officer on watchhouse duties at the Brisbane City Watchhouse on the day of Ms Long's arrest, the BWCC officers and BWCC nurse who responded to Ms Long's collapse and one of the paramedics who assessed Ms Long and transported her to the PAH.

I note the investigation report was finalised within seven months of Ms Long's death. I thank Detective Sergeant Wild for conducting a timely, thorough and professional investigation.

The Office of the State Coroner supplemented the findings of Detective Sergeant Wild's investigation by arranging for a doctor from the Queensland Health Clinical Forensic Medicine Unit (CFMU) to review the investigation material to assess whether Ms Long was given appropriate access to, and received adequate medical and emergency treatment while she was in custody. This review was undertaken by the CFMU Director, A/Professor Bob Hoskins.

The inquest

An inquest was held in Brisbane on 16 August 2010. Ms Kirkegaard was appointed as counsel to assist me. Leave to appear was granted to Ms Zerner who appeared for Dept Community Safety for Qld Corrective Services and to Ms Kilroy who appeared for Sisters Inside. Sharon Fisher, Kerry-Ann Long's sister attended the inquest.

All of the statements, photographs and materials gathered during the investigation were tendered.

Ms Kirkegaard submitted the material tendered was sufficient to enable me to make the findings required by the Act and there was no other forensic purpose to be served by the calling of any oral evidence. I accepted that submission.

The evidence

I have considered all of the evidence but refer only to those matters necessary to understand the findings I have made.

Personal background

Ms Long struggled with drug addiction for most of her adult life and had been on the methadone program for a long time.

Ms Long had two children from a de facto relationship that ended in 2000. Both children lived with Ms Long until 2007 when the eldest child ran away to live with her father who had since repartnered. Subsequent Family Court proceedings resulted in parenting orders whereby the couple's daughter remained with her father and their son remained with Ms Long. These orders incorporated conditions that both parents refrain from engaging in drug use and criminal activity.

Ongoing concerns about Ms Long's drug use and its impact on her ability to care properly for her son were investigated by the relevant authorities and caused significant acrimony between Ms Long and her former partner. It was widely recognised that it was extremely important to Ms Long that her son remain living with her.

Ms Long lived with her mother for several years prior to her mother's death. She was subsequently convicted by the Brisbane Magistrates Court of several fraud offences relating to misappropriation of her mother's money. This placed her in conflict with her siblings. She was sentenced to 12 months imprisonment and given immediate parole.

Ms Long's drug use, financial difficulties and the difficulty of her relationship with her former de facto partner and other members of her family were significant stressors in her life. She was also facing eviction from her home around the time she was taken into custody.

Basis for imprisonment

Ms Long had a lengthy history of drug, fraud and property offences going back to 1984. In July 2008, she was convicted by the Brisbane Magistrates Court of a range of fraud offences, for which she was sentenced to 12 months imprisonment and immediately released to court ordered parole. Ms Long was required to abstain from all illicit substances as a condition of her parole.

In January 2009, Ms Long provided a urine sample that tested positive to morphine and cannabis. Consequently, the Southern Queensland Regional Parole Board suspended her parole and issued a return to prison warrant. The warrant was served on Ms Long at her home on 28 January 2009, shortly before she was due to appear in the Holland Park Magistrates Court in relation to charges of possessing cannabis. Ms Long was then taken to the Brisbane City Watchhouse where the warrant was processed.

Ms Long appeared before the Holland Park Magistrates Court the following day, where she pleaded guilty to charges of possessing cannabis. She was convicted and fined, with no time to pay. Ms Long defaulted and was arrested

immediately to serve a six day custodial sentence, concluding on 3 February 2009. She was transferred from police custody to the BWCC on the afternoon of 30 January 2009.

In the meantime, the Southern Queensland Regional Parole Board had reviewed the circumstances of her parole breach and decided on 27 January 2009 to suspend her parole for two months from the date of her return to custody. This decision effectively extended the period of Ms Long's incarceration to 25 March 2009.

The parole board's decision was issued on 3 February 2009 and faxed to the Sentence Management section of the BWCC at 3:07pm that afternoon. There is no evidence to suggest Ms Long had been informed of this decision before her collapse later that afternoon.

Ms Long's medical history

The medical records maintained by Ms Long's general practitioner, Dr Baster, show that Ms Long had been diagnosed with hepatitis B and hepatitis C in 1990. She was diagnosed with rheumatoid arthritis in 2002 and was under the care of the PAH rheumatology unit. She was prescribed Salazopyrin for this condition.

Dr Baster's medical records show Ms Long was on the methadone program. She had also been prescribed antidepressants following her mother's death in early 2008 and was taking Zoloft at the time of her death.

Statements from Ms Long's family members and her close friend described Ms Long's health as generally poor, with noticeably increased anxiety and decreased appetite in the weeks preceding her death.

Assessment of Ms Long's health and medical history on being taken into custody

Ms Long was required to answer a series of medical and health questions when she was processed at the Brisbane City Watchhouse at approximately 11:00am on 28 January 2009.

A statement provided by Sergeant Robertino Patane, who administered the questionnaire to Ms Long, indicates she disclosed a medical history consistent with that shown by Dr Baster's medical records. She also advised that her current medications were Biodone, Salazopyrin, ibuprofen and Zoloft.

Sergeant Patane states he referred Ms Long for review by the watchhouse nurse at the earliest convenience. His statement indicates Ms Long was co-operative and seemed relaxed during his dealings with her.

The watchhouse medical records show Ms Long was given her prescribed antidepressant and rheumatoid arthritis medication at the prescribed doses

while she was in the watchhouse over the period 28 – 30 January 2009. She was also given Codapane Forte for the pain associated with her rheumatoid arthritis.

These records show that Ms Long did not receive methadone on her first day in the watchhouse, but it was given to her on each of the following mornings.

The corrective services medical records show that on reception to BWCC on 30 January 2009, Ms Long's medical history disclosure was consistent with that made at the watchhouse. She denied any headache and on examination, her pulse and blood pressure were normal.

The medical notes show that Ms Long was reviewed by a medical officer on 3 February 2009. She was noted as having no clinical complaints other than her pre-existing rheumatoid arthritis.

The correctional centre medical notes show that Ms Long received her prescribed medication, including the methadone, at the prescribed doses on each day she was in custody. Ms Long's request for codeine phosphate and diazepam were reviewed and refused by a medical officer.

The correctional centre medical records show that Ms Long did not seek or require any nursing or medical assistance prior to her sudden collapse.

Events leading to Ms Long's telephone discussion with her father on 3 February 2009

A statement provided by Ms Long's close friend, Ms Lynell Harding, indicates that Ms Long had expected to receive a custodial sentence of 12 – 28 days for her most recent drug convictions. For this reason, on the evening before her scheduled court appearance, Ms Long arranged for her son Kyle to stay with Ms Harding while she was in custody.

Ms Harding's statement indicates that due to the ongoing parental responsibility dispute with the child's father, Mr Lauchlin Jack, Ms Long wanted to keep the fact of her going into custody a secret. Consequently, she told Mr Jack she was going to Maryborough to look after her father as he was unwell. This is supported by statements provided by both Mr Jack and Mr Long.

The statements provided by Ms Harding and Mr Jack indicate that shortly after Ms Long was taken into police custody, Ms Harding told Mr Jack the truth about why she was looking after his son. Mr Jack collected his son from Ms Harding on 29 January 2009.

Mr Jack states that as Ms Long's drug conviction breached a condition of the parenting orders made in respect of his son, he decided to pursue sole parenting responsibility and indicated this intention to Ms Long's father and

brother on 30 January 2009.

Ms Long collapses

The correctional centre call activity report shows that Ms Long made a very brief telephone call to her father shortly before 5:15pm on 3 February 2009. This is the only phone call she made while in custody at BWCC. A recording of this call reveals that Ms Long asked her father to pass on a message to her son. Mr Long then told her that her son was with Mr Jack. Ms Long terminated the call.

Statements provided by a number of prisoners who were nearby at the time indicate that Ms Long was very distressed after the call ended. She walked away from the phone into the adjacent exercise yard and sat down on a metal bench with two fellow prisoners. She was crying and heard to say that her former partner had taken her son. Another prisoner went to get Corrective Services Officer Nicolette White from the nearby officers' station to help comfort Ms Long. CSO White attended the scene immediately. CCTV footage of the area confirms this sequence of events and shows this occurred at 5:15pm.

The prisoners who were consoling Ms Long stated that Ms Long then went pale and started to shake. CSO White states that when she arrived on the scene she saw Ms Long sitting on the bench, leaning back against the wall. Ms Long did not respond to her questioning about what had happened. CSO White states that Ms Long then gasped, her eyes rolled back and her head jerked back against the wall. CSO White immediately called a Code Blue. While she waited for help, CSO White observed Ms Long to continue gasping and jerk her head back several times.

Emergency medical response

CCTV footage shows that a number of corrective services officers attended the scene at 5:16pm, followed by registered nurse June Cooper at 5:17pm.

Nurse Cooper's statement indicates that she found Ms Long sitting on the bench supported by CSO White. Ms Long was taking slow gasping breaths. Nurse Cooper attached an oxygen mask and then assessed Ms Long's condition. She observed that Ms Long's skin was blue; she was non-responsive and had no pulse. Nurse Cooper immediately commenced cardiopulmonary resuscitation.

Registered nurses Sue Armstrong and Leslie Turner then arrived on the scene at 5:18pm with a medical response trolley. Nurse Cooper's statement and the correctional centre medical notes indicate that Ms Long received continuous oxygen supplementation, while resuscitation efforts were made including defibrillation and continued CPR. This is confirmed by the CCTV footage.

Nurse Cooper states that Ms Long stopped breathing during the resuscitation. All three nurses continued to deliver CPR and achieved a return of spontaneous circulation. Ms Long started breathing again and received breathing support until the paramedics arrived. Her pupils were noted to be fixed and dilated.

A statement provided by one of the advanced care paramedics who attended the scene, Mr John Latham, indicates that the BWCC contacted QAS at 5:24pm. One unit was dispatched at 5:27pm and arrived at the BWCC at 5:38pm. CCTV footage shows that the first paramedic arrived on the scene at 5:45pm, followed by two others at 5:50pm.

On examination, Ms Long had a pulse, atrial fibrillation and was breathing spontaneously at 10 breaths per minute. She was noted to have a dilated left pupil and assessed with a very low Glasgow Coma Scale of 3. Ms Long was unable to be intubated at the scene due to her strong gag reflex.

The CCTV footage shows that Ms Long was transported from the scene at 6:06pm.

The precise timing of the sequence of events to this point recorded in the correctional centre medical records is slightly inconsistent with that of the CCTV footage. However, the statement provided by CSO White indicates these times reflect those she made according to her watch as she kept a running sheet of the resuscitation. CSO concedes that her record of these times may not have been the same as the CCTV footage for this reason.

Mr Latham's statement indicates they left BBWC at 6:14pm. A roadside rapid sequence induction to facilitate endotracheal intubation was done at 6:22pm en route to the PAH.

Ms Long arrived at the PAH emergency department at 6:45pm. Her pupils were fixed and dilated on arrival. The hospital records indicate a CT brain scan noted extensive subarachnoid haemorrhage with cerebral oedema and a CT angiogram noted an 8.8mm x 8.9mm anterior communicating aneurysm.

I infer from all of the information this condition had not previously been suspected or diagnosed. Neurosurgical review determined that Ms Long's condition was inoperable. She was admitted to the PAH intensive care unit later that evening and maintained on life support while attempts were made to contact her father.

The hospital records show contact was made with Mr Long on the morning of 4 February 2009. He was told her condition was terminal and she was expected to die that day. Her brother, sister, children and Mr Jack attended the hospital. After discussion with the ICU doctor, they agreed her life support should be withdrawn. Ms Long was extubated at 2:55pm and died at 4:10pm

in the presence of several family members.

Cause of death

Dr Ong performed an external and full internal autopsy on the morning of 5 February 2009.

Consistent with the clinical findings, the autopsy found a ruptured and collapsed aneurysm within the anterior communicating artery. Heavy subarachnoid haemorrhage was present on the base of the skull, as well as on the cerebral corticies.

There was scattered pneumonia consistent with aspiration that Dr Ong considered would have occurred when Ms Long initially lost consciousness.

The examination found no evidence of trauma to the head or elsewhere.

Toxicology was performed on a hospital blood specimen taken from Ms Long at 7:00pm on 3 February 2009. It detected therapeutic levels of the drugs administered during resuscitation. Elevated methadone levels, as well as a metabolite of cannabis were also detected. In this regard, Dr Ong noted that cannabis and methadone are known to have a long half life and can be detected even after days of abstinence.

On the basis of these findings, Dr Ong concluded the cause of Ms Long's death was subarachnoid haemorrhage as a consequence of a ruptured saccular aneurysm. Dr Ong's report notes this aneurysm forms from a weakened spot in the arterial wall and is known to rupture spontaneously without any trauma. He found nothing to indicate any other person was involved in Ms Long's death.

Adequacy of medical and emergency treatment provided to Ms Long

Dr Bob Hoskins, Director of Queensland Health's Clinical Forensic Medicine Unit (CFMU) was asked to review the investigation material to assess the adequacy of the medical and emergency treatment provided to Ms Long while she was in custody.

Statements from several of the prisoners accommodated in the same unit as Ms Long suggested she had been denied her medication. The hospital emergency admission records note Ms Long had refused methadone for the last two days.

Dr Hoskins' review of the watchhouse and correctional centre medical records confirmed that Ms Long received all of her prescribed medication at the prescribed doses while she was in custody, other than one dose of methadone when she was taken into police custody on 28 January 2009. Dr Hoskins advised this is consistent with current policy to withhold potentially

dangerous drugs, such as methadone, until a person has been in custody and is not obviously intoxicated for 24 hours. This precaution prevents prescribed medication being administered on top of whatever drugs a person may have used in the community before their arrest.

Dr Hoskins suggested the correct annotation for a regular dose - "R" - that appears in the watchhouse and correctional centre medication records could have been misinterpreted by someone unfamiliar with those forms, when Ms Long was admitted to the PAH emergency department. This would account for the notation that Ms Long had refused her methadone for the preceding two days.

Statements provided by Ms Harding and Mr Jack suggest Ms Long had complained of headaches and migraines in the past. Dr Hoskins noted that on reception at BWCC on 30 January 2009, Ms Long denied any headache and her pulse and blood pressure were normal. Dr Hoskins noted further that there was nothing in the correctional centre medical records to suggest Ms Long had made any complaints to BWCC staff that could or should have alerted them to a developing intracranial bleed.

Dr Hoskins considered the timeliness and adequacy of the BWCC response to Ms Long's collapse could not be criticised. He noted Ms Long's oxygen saturation levels did not fall below 95% during active resuscitation. He commented that although this is low, it is not unacceptably low and is indicative of effective resuscitative attempts.

Dr Hoskins noted that the paramedics arrived on the scene 35 minutes after the Code Blue was called. He considered this a very timely response to an emergency situation in a correctional centre environment.

Dr Hoskins did not have any concerns about the standard or level of care provided to Ms Long by the PAH.

Investigation findings

Ms Long's body was formally identified by her sister in the PAH intensive care unit, shortly after she died.

Ms Long's collapse at the BWCC was witnessed and she remained under escort by corrective services officers from the time she was transferred by ambulance to the PAH until she died.

Autopsy examination confirmed the clinical findings of extensive subarachnoid haemorrhage and anterior communicating aneurysm. The pathologist found no evidence of trauma to the head or elsewhere. I note the pathologist's advice that this type of aneurysm is known to rupture spontaneously and unexpectedly without any trauma.

Independent medical review confirmed Ms Long's current state of health and medical history were adequately assessed both when she was taken into police custody at the Brisbane City Watchhouse and then on reception at BWCC. The review confirmed that Ms Long was given appropriate access to her prescribed medication while she was in custody and further that she did not present with any symptoms indicative of a developing intracranial bleed. The review also confirmed the timeliness and adequacy of the emergency medical response to Ms Long's collapse and the treatment she received at the PAH.

No evidence suggested anything other than a death by natural causes.

Findings required by s45

I am required to find, as far as is possible, the medical cause of death, who the deceased person was and when, where and how she came by her death. As a result of considering all of the material contained in the exhibits, I make the following findings.

Identity of the deceased – The deceased person was Kerry-Ann Long who was born in Brisbane, Queensland on 28 May 1966.

How she died – Ms Long died of natural causes while a prisoner at the Brisbane Women's' Correctional Centre.

Place of death – She died in the Princess Alexandra Hospital Intensive Care Unit.

Date of death – Ms Long died on 4 February 2009.

Cause of death – She died from subarachnoid haemorrhage as a consequence of rupture of saccular aneurysm of the anterior communicating artery.

Comments and recommendations

Section 46, insofar as it is relevant to this matter, provides that a coroner *may* comment on anything connected with a death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.

Leave was granted to Ms Kilroy appearing at the inquest to a limited extent. I noted the positive and supportive work performed by Sisters Inside for female prisoners. Ms Kilroy for Sisters Inside sought to include as an issue in this inquest the psycho-social support available to Ms Long relating to the care of her son at the time of her death as a matter that could be commented upon by

the coroner. She submitted this issue was the most significant issue/event that Ms Long experienced prior to her collapse on 3 February 2010.

Ms Kilroy sought further evidence be produced to the inquest about these matters.[2] She referred to the generally poor state of health of female prisoners when compared with the broader population and an estimate of the number of female prisoners who are parents of dependent children at the time of their incarceration.

I accept there was a temporal connection between Ms Long receiving information her son was not where she had arranged and was now in the care of his father, and Ms Long's collapse. The phone call immediately preceded her becoming physically and emotionally distressed and then collapsing. However the medical evidence is she was suffering from a previously unknown condition which could lead to death at any time.

I have found that Ms Long died of natural causes and that the response to her sudden collapse was timely and appropriate. There was no basis to be critical of the health care afforded to her while in custody.

I note Ms Long had made arrangements for her son prior to her incarceration.

In the circumstances, I consider there is no basis on which I could make any preventative recommendations which could help prevent a death occurring in similar circumstances.

I close the Inquest.

Christine Clements
Deputy State Coroner
Brisbane
20 September 2011

[2] Submissions dated 17 September 2010